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## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-046257  
STATE FILE NUMBERDO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 121

FILED DEC 18 1962

VS 300  
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>		c. CITY OR TOWN <b>Excelsior Springs</b>	
Length of stay in 1b <b>22 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Spa-View Rest Haven</b>		d. STREET ADDRESS (If outside, give location) <b>812 Magnolia</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Hickman</b> Last <b>Hill</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7-27-1877</b>
9. AGE (last birthday) <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M. D.</b>	
11. BIRTHPLACE (City and state or country) <b>Independence, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Maude Hill</b>		Address <b>812 Magnolia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>[redacted]</b>	
17. INFORMANT <b>Mrs. Harry Boyd, Excelsior Springs, Mo.</b>		Address <b>812 Magnolia</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sev. days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic heart disease</b>		<b>sev. years</b>	
DUE TO (c) <b>arteriosclerosis, severe.</b>		<b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>[redacted]</b> a.m. <b>[redacted]</b> p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Excelsior Springs, Mo.</b>		
20g. COUNTY <b>Clay</b>		20h. STATE <b>Missouri</b>	
21. I attended the deceased from <b>Jan. 12, 1962</b> to <b>Nov. 2, 1962</b> and last saw <b>her</b> alive on <b>Nov. 2, 1962</b> Death occurred at <b>5:00 p.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>M. D.</b>	
22b. ADDRESS <b>Excelsior Springs, Mo.</b>		22c. DATE SIGNED <b>11/6/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-5-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
24. FUNERAL DIRECTOR <b>Prichard Funeral Home, Inc.</b>		25. PATR. RECD. BY LOCAL REG. <b>[Signature]</b>	
ADDRESS <b>Excelsior Springs, Missouri</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

(Licensed Embalmer's Statement on Reverse Side)

DEC 19 1962

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lindsey Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Burial Permit Issued 11-2-62 E. H.